1 - Office 4 - Home 8 - Correctional Facility 11 - Faith-based 14 - Client's Job Site 17 - Non-Traditional 20 - Telehealth
2 - Field 5 - School 9 - Inpatient 12 - Health Care 15 - Adult Residential 18 - Other 21 - Unknown
3 - Phone 6 - Satellite Clinic 10 - Homeless 13 - Age-Specific 16 - Mobile Service 19 - Childrens Residential

DATE: BILLING TIME: LOCATION: ☐ SERVICE TYPE: **ASSESSMENT**
(If the same person completes all parts, all billing may be done above on this page.)

ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE"). THE ASSESSMENT SHOULD ILLUSTRATE ALL MEDICAL NECESSITY PRESENT AND PROVIDE THE BASIS FOR THE DSM-4 DIAGNOSIS.

**(PART 1) TRIAGE/SCREENING**

Sources of information: minor ☐ other (name, role) _____

Gender: M F Marital Status: S M D W Sep Lives In/With _____

Person Giving Tx Consent: ☐ Parent(s) ☐ Guardian ☐ DCS ☐ Court ☐ Foster parent(s) ☐ Self _____

Referral Source: ☐ Person(s) child is living with ☐ School ☐ CPS ☐ Court ☐ Probation ☐ Self _____

PRESENTING PROBLEM/HISTORY OF CURRENT PROBLEMS (Include significant problems with regard to daily living, such as with responsibilities, social relations, living arrangement, and health. Include cultural explanations of problems if these are important to client.)

_____

_____

_____

_____

_____

Previous Inpatient and Outpatient Mental Health Tx (include dates, providers, diagnosis, results, and when most recent meds taken):

Previous inpt tx: ☐ None _____

Previous outpt tx: ☐ None _____

Most Recent Psychotropic Meds and When: ☐ Never _____

Previous Suicide / Homicide History

Suicide Attempts: ☐ None _____

Previous Homicide ☐ None _____

Substance Problems (describe past and present use of tobacco, alcohol, caffeine, drugs, and medicines)

Substances used: ☐ None _____

Time of last use: ☐ Never used _____

Age when first used: ☐ N/A _____

Frequency and quantity of use: ☐ N/A _____

Use of drugs intravenously: ☐ Never ☐ Not currently _____

Hx of withdrawal symptoms (sick, shaky, depressed, etc.): ☐ None _____

Hx of tolerance (use of more of the substance to get same effect): ☐ Never _____

Unsuccessful efforts to cut down or stop: ☐ None ☐ Never tried ☐ N/A _____

Problems with family or friends because of substance use: ☐ None _____

Legal problems related to substance use: ☐ Never _____

Hx of substance tx: ☐ None _____

_____

_____

_____

Current Health Problems: ☐ None _____

Current Health Conditions Placing Client at Special Risk: ☐ None _____

Currently Pregnant? ☐ Yes ☐ No _____

Allergies to Medicines or Other Substances: ☐ None _____

Other Agencies/Providers Client is Involved With: ☐ None _____

RISK *(CLINICAL MASTERS LEVEL OR ABOVE ONLY)*

Risk For Abuse And/Or Victimization: ☐ Non-significant _____

Current Suicide, Homicide, Assaultive Behavior and Other Risks: ☐ None noted _____

_____

INITIAL INDICATIONS OF DYSFUNCTION (consider work, school, home, peer, family, parenting, self-care, etc): ☐None

_____

_____

ADDITIONAL ASSESSMENT ISSUES (including reasons for NOA, if issued): ☐ None _____

_____

DISPOSITION: List actions taken, recommendations, and referrals made (mental health tx, drug/alcohol tx, community resources, medical care, etc). Include preferred language for services and provider gender and ethnicity if these are important to client: _____

_____

SIGNATURE _____ PRINTED NAME _____

DATE _____

SIGNATURE _____ PRINTED NAME _____

DATE _____

**1-OFFICE 4-HOME 5-SATELLITE 6-SCHOOL 2-OTHER FIELD (ADD CODE 3 IF NON-FACE-TO-FACE) (LOC IS 1 IF NOT SPECIFIED)**

DATE: BILLING TIME: LOCATION: ☐ SERVICE TYPE: **ASSESSMENT**

(If the same person completes all parts, all billing may be done above on this page.)
ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE"). THE ASSESSMENT SHOULD ILLUSTRATE ALL MEDICAL NECESSITY PRESENT AND PROVIDE THE BASIS FOR THE DSM-4 DIAGNOSIS.

**(PART 2) ADDITIONAL CLINICAL ASSESSMENT**

Sources of information: ☐ minor ☐ other (name, role) _____

DEVELOPMENTAL HISTORY

Pregnancy Planned? ☐ Yes ☐ No _____ Complications? ☐ Yes ☐ No _____

Drug/Alcohol Impact? ☐ Yes ☐ No _____ Premature Birth? ☐ Yes ☐ No _____

Birth Complications? ☐ Yes ☐ No _____

Parents' Attitudes About Having Child: _____

Age When: Crawled? _____ Walked? _____ Spoke Single Words? _____ Spoke Sentences? _____ Toilet Trained? _____

Current Developmental Delays and Problems: ☐ None _____

_____

Birth Order: ____ of ____ Raised By: ☐ Birth Parents _____ Age At Parents' Divorce: ☐ N/A _____

FAMILY, SOCIAL, AND PROBLEM HISTORY

Siblings: ☐ None _____

Parents Are: ☐ Married ☐ Living Together ☐ Separated ☐ Divorced ☐ No Longer Connected _____

Abuse: ☐ None _____

_____

Age-Appropriate Self-Care: ☐ WNL _____

Current School _____ Yr. in School _____ Grades _____

Type of Classes: ☐ Regular ☐ Sp. Ed. (explain) _____

School Problems: ☐ None _____

_____

Behavior Problems: ☐ None _____

_____

Out of Home Placements: ☐ None _____

_____

Support System _____

Problems with Parents: ☐ None _____

_____

_____

Cultural or Acculturation-related Parenting Issues: ☐ None _____

_____

Problems with Siblings: ☐ None _____

_____

Problems with Peer Relationships: ☐ None _____

_____

Sexually Active: ☐ Yes ☐ No _____ Sexual Problems: ☐ None _____

Temper/Violence/Harm to Animals / Property: ☐ None _____

_____

Past and Current Arrests and Legal Problems: ☐ None _____

Sleep Problems: ☐ None _____

Eating Problems: ☐ None _____

Current and Past Meds (include over-the-counter, non-traditional - herbs, etc.) (include dosage if known): _____

Past: ☐ None _____

_____

Current: ☐ None _____

_____

Culture-related Healing Practices Used: ☐ _____

Past and Present Employment: ☐ Never employed _____

Importance of Religion/Spirituality For Client ☐ Not important _____

Culture/Diversity: Assess unique aspects of the client, including culture, background, and sexual orientation, that are important for understanding and engaging the client and for care planning.

Preferred language for receiving our services _____ (If **not** English, complete all items in this section.)

Nature of services and staff assigned will need to be significantly culturally-related: ☐ Yes ☐ No How? _____

_____ (If "yes", complete all items in this section.)

(If the above two items are answered “English” and “No”, respectively, the remainder of this section is optional.)

Family's country of origin _____

No. of yrs. client and parents have been in this country: Client: ☐ All his/her life _____ Parents: ☐ All their lives _____

Culture client most identifies with _____

Problems client has had because of his/her cultural background: ☐ None _____

_____

Additional cultural/diversity assessment (optional): ☐ None _____

_____

_____

_____

Sexual Orientation Issues: ☐ None _____

Support/Involvement of Family in Client's Life: ☐ _____

Desire of Client for Involvement of Family or Others in Tx: ☐ Desires _____

_____

Client Strengths _____

Client Motives For Services / What Does Client Really Want From Services? _____

Why Is Client Coming For Help Now? _____

MENTAL STATUS (CLINICAL MASTERS LEVEL OR ABOVE ONLY)

(Consider what is within normal limits for the client's culture and background)

Appearance/Behavior: _____

Orientation: Oriented to ☐ Person ☐ Place ☐ Time ☐ Situation _____

Speech _____

Intellectual Functioning Estimate: ☐ Above avg. ☐ Average ☐ Below avg. ☐ M.R. _____

Memory: ☐ No problems _____

Thought Processes _____

Other Cognitive Deficits: ☐ None noted _____

Thought Content/Delusions: ☐ No problem _____

Perceptual Processes/Hallucinations: ☐ No problem _____

Insight _____

Judgment _____

Mood _____

Affect _____

ADDITIONAL ASSESSMENT ISSUES (including special needs with respect to receiving services and reasons for NOA, if issued): ☐ None _____

DYSFUNCTION REQUIRING TREATMENT (consider work, school, home, peer, family, parenting, self-care, etc): ☐None ☐ Same as Part 1_____

DISPOSITION List actions taken, recommendations, and referrals made (mental health tx, drug/alcohol tx, community resources, medical care, etc.). Include preferred language for services and provider gender and ethnicity if these are important to client ☐ Same as Part 1_____

FORMULATION/EXPLANATION OF PROBLEMS (optional): _____

(Outlines for more extensive assessments of cultural issues, sexual orientation/gender issues, assaultive behavior, and firesetting are available. Such assessments should be attached to this form.)

(All staff participating sign below.)

SIGNATURE _____ PRINTED NAME _____

DATE _____

SIGNATURE _____ PRINTED NAME _____

DATE _____

**CHILD/ADOL CLINICAL ASSESSMENT**
**San Bernardino County**
**DEPARTMENT OF BEHAVIORAL HEALTH**
**Confidential Patient Information**
**See W&I Code 5328**

**NAME:**

**CHART NO:**

**DOB:**

**PROGRAM:**

ASSESSMENT UPDATE

Update entries may be made here of important background information or other assessment information about changes in the client's circumstances discovered during the course of services. All entries will be dated and signed as a regular chart note. If an interview takes place, it may be charted here and billed by adding the MHS-Assess. heading, the billing time, and the location code.

**CHILD/ADOL CLINICAL ASSESSMENT**
**San Bernardino County**
**DEPARTMENT OF BEHAVIORAL HEALTH**
**Confidential Patient Information**
**See W&I Code 5328**

**NAME:**

**CHART NO:**

**DOB:**

**PROGRAM:**